

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

6) 445-1161

September 4,

TO: ALL CMSP COUNTY WELFARE DIRECTORS

CMSP Letter 85-6

REVISED FORM CMSP 1153 - COUNTY MEDICAL SERVICES PROGRAM/MEDI-CAL LINKAGE EVALUATION

This memo transmits a revised County Medical Services Program/Medi-Cal Linkage Evaluation Form (CMSP 1153). Based on recommendations of the Small County Advisory Committee (SCAC), the form was revised to facilitate the early detection of potentially disabled persons or persons otherwise eligible for Medi-Cal. The questions are designed to assist County Welfare Departments early in the screening/eligibility process to identify any potential Medi-Cal eligibility.

Significant changes in the CMSP 1153 include:

The addition of a question (#1) which establishes who is completing the application. Case history files suggest that an application is often made on behalf of a family member or friend if a severe injury has occurred or if the applicant is seriously ill. A positive response to this question should direct county welfare department staff to explore potential linkage.

The addition of a question (#2) to determine if the applicant is a resident of the county in which the application is being made. This will prevent any applications being taken from a resident of a non-CMSP county.

The addition of a question (#7) to determine if the applicant is currently receiving State Disability Benefits.

The enhancement of the question (#8) regarding receipt or application for Social Security Disability or SSI/SSP Benefits.

The enhancement of the question (#9) regarding nursing home residence.

The addition of a question (#10) regarding the receipt of homemaker chore/in-home supportive services.

The addition of a question (#14) regarding receipt or application for Aid to Families with Dependent Children Benefits.

The addition of a question (#15) regarding Veteran status

The addition of a question (#16) regarding receipt or application for Veteran benefits.

The addition of a question (#17) to determine if the applicant is currently in the hospital and the expected length of stay.

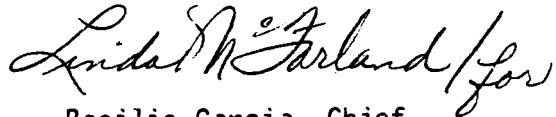
This form should be used immediately upon receipt. **THE ATTACHED IS A CAMERA-READY COPY FOR YOUR FORM REPRODUCTION.** Any existing supplies should be destroyed. Please remove the existing form CMSP 1153 from all copies of the CMSP Manual and substitute a copy of this revision.

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If you have any questions about the revised CMSP 1153 please call Linda McFarland at (916) 324-4203.

Thank you for your cooperation and assistance in this matter

Sincerely,

A handwritten signature in cursive script that reads "Linda McFarland" followed by a slanted line, likely indicating a signature for another person.

Bacilio Garcia, Chief
County Medical Services Program
County Health Services Branch

OCHB/CMSP:1153

CASE NAME: _____

CASE NO _____

NAME: _____
(Person Completing Form) (Date)

To help us determine your eligibility for medical assistance through the County Medical Services Program, or the Medi-Cal Program, please answer the following questions:

1. Are you applying for another person? Yes ☐ No ☐

If the answer to this question is yes, for whom are you applying?

Please answer the following questions for the person for whom you are applying.

If the answer to this question is no, please answer the following questions for yourself.

2. Is applicant a resident of this county? Yes ☐ No ☐

If no, which county?

3. Is applicant under 21 years of age? Yes ☐ No ☐

4. Is applicant 65 years of age or older? Yes ☐ No ☐

5. Is applicant legally blind? Yes ☐ No ☐

6. Is applicant unable to work because of a physical or mental illness, disability, or impairment that is expected to last for longer than one year? Yes ☐ No ☐

7. Is applicant receiving State Disability Benefits? Yes ☐ No ☐

8. Is applicant currently receiving Social Security Disability or SSI/SSP Benefits? OR Has applicant applied for Social Security Disability or SSI/SSP benefits within the last six months? OR Is applicant planning to immediately apply for Social Security Disability or SSI/SSP benefits? Yes ☐ No ☐

9. Does applicant live in a nursing home? Yes ☐ No ☐

If yes,

Name: _____

Address: _____

10. Is applicant receiving homemaker chore/in-home supportive services? Yes ☐ No ☐

11. If applicant is an Indochinese refugee or Cuban/Haitian entrant, has applicant lived in the United States for less than 19 months? Yes ☐ No ☐

(CONTINUED ON BACK)

12. Is there a child younger than 21 years of age living in applicant's home? Yes ☐ No ☐

If yes, is one of the child's parents:

a. Deceased? Yes ☐ No ☐

b. Not living in the home? Yes ☐ No ☐

c. Unemployed? Yes ☐ No ☐

d. Over 65 years of age? Yes ☐ No ☐

e. Legally blind? Yes ☐ No ☐

f. Unable to work because of a physical or mental impairment that is expected to continue for more than one month? Yes ☐ No ☐

13. Is applicant pregnant? Yes ☐ No ☐

14. Is applicant currently receiving Aid to Families with Dependent Children (AFDC) benefits? OR Has applicant applied for AFDC benefits? OR Is applicant planning to immediately apply for AFDC benefits? Yes ☐ No ☐

15. Is applicant a Veteran? Yes ☐ No ☐

If yes,

Branch: _____

Dates of Service: _____

6. Is applicant receiving Veteran benefits? OR Has applicant applied for Veteran benefits? OR Is applicant planning to immediately apply for Veteran benefits? Yes ☐ No ☐

17. Is applicant currently in the hospital? Yes ☐ No ☐

If yes,

a. Is hospitalization due to illness? Yes ☐ No ☐

Expected length of stay -- _____ Days

b. Is hospitalization due to accident? Yes ☐ No ☐

Expected length of stay -- _____ Days

Name of third party involved in accident: _____

c. Address of Hospital

If one or more of questions #2 through #17 is checked "yes", review for Medi-Cal eligibility. If not eligible for Medi-Cal, review for County Medical Services Program eligibility.